

**University of Rhode Island
STUDENT ACCIDENT REPORT FORM**

FORM SHOULD BE COMPLETED BY INJURED STUDENT OR HEALTH SERVICE PROVIDER

Name: _____ Email: _____
 Address: _____ Phone: _____
 Date: _____ Student ID Number: _____
 Sex: Male or Female (circle one) DOB: _____
 Location where accident occurred: _____

Description of Accident: Please describe how the accident happened. What was the student doing? List any specific acts by individuals or conditions that led to the accident. (include any tools, machinery or instrument involved)

Nature of Injury			Part of Body Injured		
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Cut	<input type="checkbox"/> Scratch	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Face	<input type="checkbox"/> Leg
<input type="checkbox"/> Amputation	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Shock	<input type="checkbox"/> Ankle	<input type="checkbox"/> Finger	<input type="checkbox"/> Mouth
<input type="checkbox"/> Asphyxiation	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain	<input type="checkbox"/> Back	<input type="checkbox"/> Foot	<input type="checkbox"/> Nose
<input type="checkbox"/> Bite	<input type="checkbox"/> Laceration	<input type="checkbox"/> Splinter	<input type="checkbox"/> Chest	<input type="checkbox"/> Forearm	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Bruise	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Strain	<input type="checkbox"/> Ear	<input type="checkbox"/> Hand	<input type="checkbox"/> Teeth
<input type="checkbox"/> Burn	<input type="checkbox"/> Puncture		<input type="checkbox"/> Elbow	<input type="checkbox"/> Head	<input type="checkbox"/> Wrist
<input type="checkbox"/> Concussion	<input type="checkbox"/> Repetitive Stress Injury		<input type="checkbox"/> Eye	<input type="checkbox"/> Knee	
Other specify) _____			Other (specify) _____		
_____			_____		

Did police respond? Y or N Police Dept. Name _____ Did EMS Respond? Y or N

Did you go to the URI Health Center for treatment? Y or N

If no, where did you treat? _____

Will you need follow up treatment? Y or N If yes, type of treatment: _____

Signed: _____
Student Date

Email signed form to Risk Manager:

ERM: Risk Control and Insurance
 75 Lower College Road, Room 118, Kingston, RI 02881
 (p) 874-2591 (f) 874-9101

NOTE: Students employed by URI who are injured while at work should fill out the Incident/Injury Report at www.uri.edu/hr/forms or contact Human Resources.